General Assembly

Raised Bill No. 67

February Session, 2010

LCO No. **642**

____SB00067INS__041410___

Referred to Committee on Human Services

Introduced by:
(HS)

AN ACT CONCERNING ANNUAL BENEFITS AVAILABLE UNDER THE CHARTER OAK HEALTH PLAN.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-311 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

(a) There is established the Charter Oak Health Plan for the purpose of providing access to health insurance coverage for state residents who have been uninsured for at least six months and who are ineligible for other publicly funded health insurance plans. The Commissioner of Social Services may enter into contracts for the provision of comprehensive health care for such uninsured state residents. The commissioner shall conduct outreach to facilitate enrollment in the plan.

(b) The commissioner shall impose cost-sharing requirements in connection with services provided under the Charter Oak Health Plan. Such requirements may include, but not be limited to: (1) A monthly premium; (2) an annual deductible not to exceed one thousand dollars; (3) a coinsurance payment not to exceed twenty per cent after the

deductible amount is met; (4) tiered copayments for prescription drugs determined by whether the drug is generic or brand name, formulary or nonformulary and whether purchased through mail order; (5) no fee for emergency visits to hospital emergency rooms; (6) a copayment not to exceed one hundred fifty dollars for nonemergency visits to hospital emergency rooms; and (7) a lifetime benefit not to exceed one million dollars.

(c) The Commissioner of Social Services shall provide premium assistance to eligible state residents whose gross annual income does not exceed three hundred per cent of the federal poverty level. Such premium assistance shall be limited to: (1) One hundred seventy-five dollars per month for individuals whose gross annual income is below one hundred fifty per cent of the federal poverty level; (2) one hundred fifty dollars per month for individuals whose gross annual income is at or above one hundred fifty per cent of the federal poverty level but not more than one hundred eighty-five per cent of the federal poverty level; (3) seventy-five dollars per month for individuals whose gross annual income is above one hundred eighty-five per cent of the federal poverty level but not more than two hundred thirty-five per cent of the federal poverty level; and (4) fifty dollars per month for individuals whose gross annual income is above two hundred thirty-five per cent of the federal poverty level but not more than three hundred per cent of the federal poverty level. Individuals insured under the Charter Oak Health Plan shall pay their share of payment for coverage in the plan directly to the insurer.

(d) The Commissioner of Social Services shall determine minimum requirements on the amount, duration and scope of benefits under the Charter Oak Health Plan, except that **[**there**]** (1): There shall be no preexisting condition exclusion; and (2) a plan participant who has not exceeded the lifetime benefit shall not be denied coverage for medical treatment that the commissioner determines, based on available medical evidence, to be medically necessary. Each participating insurer shall provide an internal grievance process by which an insured may request and be provided a review of a denial of coverage under the

plan.

(e) The Commissioner of Social Services may contract with the following entities for the purposes of this section: (1) A health care center subject to the provisions of chapter 698a; (2) a consortium of federally qualified health centers and other community-based providers of health services which are funded by the state; or (3) other consortia of providers of health care services established for the purposes of this section. Providers of comprehensive health care services as described in subdivisions (2) and (3) of this subsection shall not be subject to the provisions of chapter 698a. Any such provider shall be certified by the commissioner to participate in the Charter Oak Health Plan in accordance with criteria established by the commissioner, including, but not limited to, minimum reserve fund requirements.

(f) The Commissioner of Social Services shall seek proposals from entities described in subsection (e) of this section based on the cost sharing and benefits described in subsections (b) and (c) of this section. The commissioner may approve an alternative plan in order to make coverage options available to those eligible to be insured under the plan.

(g) The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies shall be valid until the time final regulations are adopted and may include: (1) Exceptions to the requirement that a resident be uninsured for at least six months to be eligible for the Charter Oak Health Plan; and (2) requirements for open enrollment and limitations on the ability of enrollees to change plans between such open enrollment periods.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2010*	17b-311

HS *Joint Favorable*

INS *Joint Favorable*